Utah Department of Health
Bureau of Licensing

PHYSICIAN ORDER For Life-Sustaining Treatment This is a physician order sheet based on patient/resident wishes and medical indications for life-sustaining treatment. If in the clinical record, this should be the first page. In other setting, locate in a prominent place. When need occurs, first follow these orders, then contact the physician.	Last Name of Patient/Resident First Name/Middle Initial Date of Birth

Any section not completed indicates all treatment in that Section will be provided

SECTION A CHECK ONE	Treatment options when the patient / resident has no pulse and is not breathing. _____________ Resuscitate ________ Do Not Attempt or continue any Resuscitation (DNR)
SECTION B CHECK ONE ONLY	Treatment options when the patient / resident has pulse and is breathing. ______ Comfort Measures only. Oral and body hygiene, reasonable efforts to offer food and fluids orally. Medication, positioning, warmth, and other measures to relieve pain and suffering. Privacy and respect for the dignity and humanity of the patient / resident. Other instructions. Transfer only if comfort measures fail. ______ Limited additional Interventions. Includes care above. May include oxygen, suction, treatment of airway obstruction, bag-mask / demand valve, monitor cardiac rhythm, medication, IV fluids. Transfer to hospital if indicated, but no endotracheal intubation or long-term life support measures. Usually no intensive care. Other Instructions: ______ Full Treatment. Includes all care above plus endotracheal intubation and cardioversion. For Hospitalization: Transfer only if necessary to: ________________________.
SECTION C CHECK ONE ONLY	ANTIBIOTICS; Comfort measures are always provided. ______ No Antibiotics except if needed for comfort ______ Oral antibiotics ______ Invasive (IM / IV) Antibiotics Other Instructions:
SECTION D CHECK ONE ONLY	ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITIONS. Comfort Measures are always provided. ______ No Feeding Tube _______ No IV Fluids ______ Defined Trial Period of Feeding Tube / IV Fluids. ______ Long-term Feeding Tube /IV Fluids. Other Instructions:
SECTION E	Discussed with: Summarize Medical Condition: ______ Patient / Resident ______ Parent of Minor ______ Health Care Agent ______ Court-Appointed Guardian ______ Spouse ______ Other Name of Health Care Agent and Phone Number:

Signature of Person Preparing Form	Print Name and Phone Number	Date and Time Prepared
Signature of Physician (Mandatory)	Print Name, License and Phone Number	Date and Time Signed
ORIGINAL FORM MUST ACCOMPANY PATIENT /RESIDENT ON TRANSFER OR DISCHARGE		

SECTION F	Patient / Resident Preferences as a guide for Physician Order for Life Sustaining-Treatment	
I have given significant thought to life-sustaining treatment. The following have further information regarding my preferences: Advanced Directive _______ NO _______ YES Court-Appointed Guardian _______ NO _______ YES Power of Attorney for Health Care _______ NO _______ YES I expressed my preference to my physician and / or health care provider(s) and agree with the treatment order on this document. Please review these orders if there is a substantial permanent change in my health status such as: Close to Death / Advanced Progressive Illness / Improved Condition Permanently Unconscious / Extraordinary Suffering / Surgical Procedures		
Signature of Person / Guardian/ Responsible Party	Name (Type or Print) / Phone Number	Date:

How to Change "Physicians Orders for Life Sustaining Treatment"

This form, Physician's Orders for Life-Sustaining Treatment, should be reviewed if:

1. The patient / resident is transferred from one care setting to another;
2. There is substantial permanent change in patient / resident health status; or
3. The patient / resident treatment preferences change.

Review Patient / Resident Preferences as a guide for Physician Order for Life-Sustaining Treat (Section F). Record the review in Review of Physician's Orders for Life-Sustaining Treatment (Section G). To Void this FORM, a physician draws a line through the Physician's Order and / or write the word "VOID" - Sign and date the form. IF NO FORM IS COMPLETED FULL TREATMENT MAY BE PROVIDED.

SECTION G	REVIEW OF PHYSICAN ORDERS FOR LIFE-SUSTAINING TREATMENT		
Date of Review	Reviewer	Location of Review	Outcome of Review
			____ No change ____ Form Voided, No New Form ____ Changed, Reflected on Form
			____ No change ____ Form Voided, No New Form ____ Changed, Reflected on Form
			____ No change ____ Form Voided, No New Form ____ Changed, Reflected on Form